Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 07/09/01 and 12/17/01
   b. The request was received on 07/09/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Position Statement on Table of Disputed Services
   b. TWCC 66 forms
   c. EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II: No Response

3. The commission requested two copies of additional documentation via a Fee Letter (MR116) that was mailed to the provider on 07/30/02. The provider did not respond per Rule 133.307 (g)(3). Therefore, the commission could not forward any additional documentation to the Respondent per Rule 133.307 (g)(4). The carrier failed to submit any responses to the request for medical dispute. The "No Response Found in File" sheet is reflected as Exhibit II in the commission case file.

III. PARTIES' POSITIONS

1. Requestor: Table of Disputed Services
   "Letter of referral available from tx [sic] phy [sic]. To prescribing phy [sic]."

2. Respondent: No Response

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 07/09/01 and 12/17/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer. Per the requestor's TWCC-60, the amount billed is $403.35; the amount paid is $0.00; the amount in dispute is $403.50." The amount in dispute is more than the amount billed per the provider's own

Table of Disputed Services. The accurate amount in dispute is $403.35

3. The carrier denied the billed services by code, "L - >DISALLOWED: THIS PROVIDER IS NOT ON ON [sic] FILE AS THE TREATING DOCTOR FOR THIS PATIENT."

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
07/09/01 07/09/01 12/17/01 12/17/01	Levaquin 250mg x 30-units Imipramine HCL 25mg x 60 units Cephalexin 500mg x 40 units Hydrocodone/ APAP 7.5/750 x 40 units	$252.48 $46.75 $77.00 $27.12	$0.00	L	AWP/unit x number units x $1.38 + $7.50	Rule 408.021 (c); MFG PGR (II)	The carrier denied payment by exception code "L – Not Treating Doctor." ___. is the treating physician of TWCC record since 07/19/00 when the claimant requested that her treating doctor be changed from ___ to ___ There has not been another request submitted by the claimant to change doctors to date. There is no documentation that the treating doctor, ___, referred the claimant to ___. who in turn referred the claimant to ___. ___. is the doctor who prescribed the medications for the dates of service. Rule 408.021 (c) states, "…Except in an emergency, all health care must be approved or recommended by the treating doctor." The treating doctor of record did not approve or recommend the claimant to the doctor who wrote the prescriptions for the dates of service in dispute. **No** reimbursement is recommended.
Totals		$403.35	$0.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 17th day of March 2003.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm